Georgia Department of Human Resources
MENTAL HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

Please Circle Yes or No for the following questions?

1. Have you ever been in counseling/therapy for yourself and/or a family member? Yes No

   a. If so, was the counseling or therapy helpful Yes No

2. Have you ever been seen by a psychiatrist? Yes No
   Approximate date of last visit _____

3. Have you ever been a patient in a psychiatric hospital? Yes No
   If yes, approximate date of last admission _____

4. Have you ever received outpatient substance abuse treatment? Yes No
   If yes, approximate date of most recent treatment _____

5. Have you ever been a patient in a substance abuse day treatment program? Yes No
   If yes, approximate date of most recent discharge _____

6. Have you ever been a patient in a substance abuse inpatient program? Yes No
   If yes approximate date of most recent discharge _____

7. Have you ever suffered a serious head injury? Yes No
   (a) Without loss of consciousness Yes No
   If yes, approximate age of injury _____
   (b) With loss of consciousness Yes No
   If yes approximate age of injury

8. Please list all current medications. Indicate the purpose of the medications.